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COORDINATING AND EXPANDING SERVICES FOR THE PREVENTION, IDENTIFICATION AND TREATMENT OF ALCOHOL AND DRUG ABUSE AMONG INDIAN YOUTH, AND FOR OTHER PURPOSES

DECEMBER 16, 1985.—Ordered to be printed

Mr. ANDREWS, from the Select Committee on Indian Affairs, submitted the following

REPORT

[To accompany S. 1298]

The Select Committee on Indian Affairs, to which was referred the bill (S. 1298) having considered the same, reports favorably thereon with an amendment and recommends that the bill as amended do pass.

The amendment is an amendment in the nature of a substitute.

PURPOSE

The purpose of S. 1298 is to coordinate and expand services for the prevention, identification, and treatment of alcohol and drug abuse among Indian juveniles. Prevention of abuse through education is one of the key goals of S. 1298, as is the coordinated training of Bureau of Indian Affairs and Indian Health Service personnel working with Indian youth.

BACKGROUND

Alcohol and drug abuse among Indian youth has not been a focus of significant attention by either the Bureau of Indian Affairs or the Indian Health Service. There are very few comprehensive education or treatment programs targeted at addressing this serious problem—a problem that is becoming more of a threat to Indian communities every year. Neither the problem of substance abuse among Indian youth nor the attempt by Congress to address this problem is new. Recognizing the growing threat of alcohol and drug abuse among Indian youth in the late 19th Century, Congress enacted legislation requiring a comprehensive education program on alcohol and drugs and their effects upon the human system in all "Indian schools." Act of May 20, 1886, 20 U.S.C. 111 et seq. This

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legislation further addressed the serious nature of substance abuse by including an enforcement clause stating that the refusal or neglect to comply with the law's requirements was ground for removal from BIA employment.

Although the Bureau of Indian Affairs is fully aware of the Act of May 20, 1886, and includes direction for compliance with the law in its Manual of Operations, failure to include the required instruction in alcohol and drug abuse has resulted in no employee dismissals. The Bureau contends that there are alchohol and drug abuse programs in place in 122 of the 183 BIA funded schools. However, a spot check by the Committee showed that these schools, for the most part, do not appear to have formal, comprehensive programs.

Of the forty-nine BIA funded schools contacted by the Committee, seven had no programs in place, most had no formal, comprehensive curriculum, and none received funding from the BIA to operate a program. Of those schools having substance abuse programs, financial assistance was provided by either the state, Indian Health Service, Department of Education grants or tribal dollars, or a combination thereof. Examples of programs include a three day, once-a-year program on abuse, one hour guest lecturers and sporadic films. The most comprehensive program, which included curriculum and a counselor, relies solely on a Department of Education discretionary grant, which must be renewed annually.

The Committee is very concerned about the Bureau's definition of a substance abuse program and stresses that the programs required by S. 1298 are to be curriculum based programs with a minimum of one unit of instruction per school week.

The Committee also shares the concerns of the witnesses about the lack of substance abuse education in public schools. While S. 1298 provides for training of public school personnel, it does not require instruction on substance abuse in public schools, nor does it provide authorization for appropriations for such programs. The Committee encourages tribes and public schools to work together to develop programs geared toward Indian youth substance abuse and to utilize available program monies, such as the Department of Education's Indian Education Act (Title IV) and the BIA's Johnson O'Malley programs, where the community finds substance abuse to be a problem.

Since alcohol and drug abuse among Indian youth has not been a high "priority" issue at either the Bureau or the Indian Health Service, there are no accurate statistics showing how many youth are affected. A 1982 Report by the BIA's Office of Indian Education Programs, Division of Student Support Services, shows that in BIA and tribal schools there is an "overall lack of mechanisms in place to allow early detection and treatment" of alcohol and drug abuse. The report cites lack of trained personnel, lack of education, lack of crisis intervention and treatment, and lack of a uniform perception regarding what constitutes alcohol and drug abuse. This study was performed in response to a BIA estimate that ninety percent of all student behavorial problems were alcohol and drug related.

Among the Indian witnesses and the IHS, BIA and tribal officials who testified before the Committee on S. 1298, there is little doubt that alcohol and drug abuse is a leading cause of the school dropout rate, premature death, suicide, and criminal arrests of Indian

youth. There is also little doubt that abuse is on the rise with new chemicals coming into play—drinking of alcohol is reportedly being combined with drinking disinfectants; sniffing paint and glue is being combined with sniffing typewriter correction fluid and spray disinfectants.

S. 1298 requires the Secretary of Health and Human Services to conduct a study on the size of the youth population in need of treatment, the location of available treatment centers, and the cost of providing treatment. The Committee stresses that this study is to be done in consultation with Indian tribes and encourages the Secretary to work with tribes in formulating a definition of what constitutes alcohol and drug abuse so that the study will accurately reflect the exact nature of substance abuse among Indian youth.

Because the BIA withdrew from providing direct educational services to Native Alaskans, upon the completion of the transfer of BIA schools to the State of Alaska, the Committee stresses that Alaskan Native villages and regional corporations are to be consulted by both the Secretary of the Interior and the Secretary of Health and Human Services in all aspects of the implementation of S. 1298, including, but not limited to, the provisions of Section 102 for the coordination and identification of local resources and services related to Indian youth alcohol and drug abuse.

Summary of Provisions

Title I of the bill directs the Secretary of the Interior and the Secretary of Health and Human Services (HHS) to enter into a written agreement, within six months of enactment, to coordinate BIA and IHS alcohol and drug programs, identify governmental and private resources, delineate the BIA's and IHS' responsibilities and determine the scope of the problem, in terms of both financial and human costs. Biennial review of the agreement is required, and Indian tribes and organizations are to be consulted before the agreement is finalized.

Title I also requires that any Indian tribe may request to coordinate resources and services within its service area. Such agreement is to be reviewed and modified to reflect changes in the availability of resources and services.

Title II requires that all BIA schools, including tribal contract schools, provide a program of instruction regarding alcohol and drug abuse to all students from kindergarten through grade twelve. The programs shall be developed in consultation with the tribe and local education and health personnel and family participation is encouraged.

Title II also requires, within nine (9) months of enactment, the publication of a newsletter reporting on Indian alcohol and drug abuse projects and programs. This newsletter is to be circulated free of charge to schools, tribal, BIA and IHS offices and other entities providing alcohol and drug abuse related services to Indian people.

Title III provides for training programs for BIA and IHS employees and emergency shelter supervisors, including a two week training program for new community health representatives/aides. These programs shall include instruction of all facets of alcohol

and drug abuse, and shall be integrated for all participants and in local communities, wher practicable. Training shall also be provided, upon request, to members of school boards or local school personnel in schools with at least 20 percent Indian enrollment, urban Indian center personnel, tribal judges, tribal and governmental juvenile workers, BIA law enforcement officers, and local and tribal persons working with Indian youth.

Title IV requires the Secretary of Interior, in consultation with the U.S. Attorney General, to publish guidelines for tribal or Federal law enforcement officers regarding the placement of Indian youth, arrested for a drug or alcohol related offense, in emergency shelters, community treatment facilities, jails or hospital facilities.

Title IV also provides for the establishment of emergency shelters to house, when appropriate, Indian juveniles arrested for drug or alcohol related offenses. In establishing such a shelter, the tribe must approve the shelter, the supervisor must receive the training specified in Title III, and the shelter must be licensed. Cost of construction of these shelters is not authorized.

Title V requires the President to submit an estimate of the cost of providing comprehensive alcohol and drug abuse treatment services. Title V also requires the Secretary of HHS, in consultation with the tribes, to complete a study determining the size of the Indian juvenile population in need of residential treatment, the local at which such treatment is available or could be made available and the cost of providing treatment. Federal, tribal, local and private hospitals or facilities may be utilized, if suitable, and may be renovated pursuant to an agreement between the Secretary of HHS and the owner. If there are inadequate existing facilities available, the Secretary of HHS shall seek specific authority to construct facilities as necessary to meet the treatment needs.

Title VI contains the definitions for use in this Act, authority for the promulgation of regulations and an open-ended authorization. Based on the definitions, the service population includes members of federally-recognized tribes and Alaska Native villages and regional or village corporations who are under the age 19.

Legislative History

S. 1298 was introduced on June 13 (legislative day June 3), 1985 by Senators Andrews, Melcher, Abdnor, Murkowski, Pressler, Goldwater, DeConcini, East, Burdick, Bingaman, Cochran, Helms, and Stevens. Senators Bradley, Nickles and Kennedy have joined as cosponsors since that date. The bill was referred to the Select Committee on Indian Affairs, which held a hearing in Washington, D.C. on September 18, 1985, and a staff field hearing on October 25, 1985, in Anchorage, Alaska.

Two similar bills, H.R. 1156 and H.R. 2624, have been introduced in the House of Representatives and referred to the House Interior and Insular Affairs Committee, the Education and Labor Committee and the Energy and Commerce Committee. The House Interior Committee has held three field hearings and a Washington, D.C. hearing.

Committee Recommendations and Tabulation of Vote

The Select Committee on Indian Affairs, in open business session on November 7, 1985, by a unanimous vote of a quorum present, recommends that the Senate pass S. 1298, as amended.

Committee Amendments

The Committee recommends an amendment in the nature of a substitute.

The following is a section-by-section analysis of the bill as reported.

Section 101. Requires the Secretary of Health and Human Services to take action to enter into a written agreement with the Secretary of Interior to coordinate BIA and IHS Indian youth alcohol and drug abuse programs; identify other available resources to combat youth substance abuse; delineate BIA's and IHS's responsibilities in this area; determine the scope and cost of the abuse; and authorize local BIA and IHS personnel to coordinate locally available programs with the tribes. Provides for biennial review and modification of the agreement and for tribal consultation in developing the agreement, which shall be published in the Federal Register within 180 days.

Section 102. Allows tribes to, upon request, coordinate resources and locally available services by agreement with the Secretary of Health and Human Services.

Section 201. Requires programs of instruction regarding alcohol and drug abuse in all BIA and contract schools, grades kindergarten through 12. Such programs shall be developed in consultation with the local tribe and shall encourage family participation.

Section 202. Requires the Secretary of Health and Human Services within nine (9) months, to publish a quarterly newsletter reporting on Indian alcohol and drug abuse programs and provide this to schools, BIA and IHS offices and entities providing alcohol and drug abuse services.

Section 203. Provides for clinical psychology to be an eligible field of study for Title IV, Indian Education Act fellowships.

Section 301(a). Provides for not less than 80 hours of instruction in the area of alcohol and drug abuse in the initial training program for new community health representatives and aides.

Section 301(b)(1). Requires the Secretary of Health and Human Services to train, either directly or through contract, BIA and IHS personnel, including personnel of contracted programs, and emergency shelter supervisors, who work with Indian youth in the area of alcohol and drug abuse.

Section 301(b)(2). Requires the Secretary of Health and Human Services, upon request, to offer instruction in the area of alcohol and drug abuse to certain public school personnel, urban Indian center personnel, appropriate court personnel and judges, BIA law enforcement officers and local and tribal persons who are responsible for or work with Indian youth.

Section 301(b)(3). Requires the Secretary of Health and Human Services to provide the instruction either free of charge or at a charge not exceeding the direct cost for providing the instruction.

Section 301(b)(4). Allows the Secretary of Health and Human Services to provide the instruction either free of charge or at a charge not exceeding the direct cost for providing the instruction.

Section 301(b)(5). Requires the Secretary of Health and Human Services to coordinate the planning of the instruction in (b)(1) with the Secretary of the Interior.

Section 401(a). Requires the Secretary of the Interior, in consultation with the U.S. Attorney General, to promulgate guidelines under which any tribal or Federal law enforcement officer may place an Indian youth arrested for an offense in which drugs or alcohol was a contributing factor in an appropriate facility. These guidelines shall be made available to any State which exercises criminal jurisdiction over any part of Indian country.

Section 401(b)(1). Requires the Secretary of Health and Human Services, with concurrence of the Secretary of the Interior, to establish standards for licensing temporary emergency shelters to house Indian youth apprehended by a law enforcement officer for an offense in which substance abuse was a contributing factor.

Section 401(b)(2). Allows tribes to adopt the Secretary's standards and issue licenses to shelters that qualify or, if the tribe does not elect to license shelters. Licenses are subject to annual renewal, and, if a shelter fails to comply with the standards, its license shall be revoked by the tribe or the Secretary of Health and Human Services.

Section 401(b)(3). Requires that supervisors of shelters must have completed the training under Section 301(b)(1) as a condition of the shelter being licensed.

Section 401(b)(4). Provides that construction costs of shelters are not authorized by this Act.

Section 501. Requires the Secretary of Health and Human Services to submit to Congress, when the budget for each succeeding fiscal year is submitted, a detailed estimate of the cost of providing a comprehensive youth alcohol and drug abuse treatment.

Section 502. Requires the Secretary of Health and Human Services, in consultation with tribes, within one year, to complete a study on the size of the youth population in need of treatment, the location of residential facilities at which treatment is available or could be available, and the cost of providing the treatment.

Section 503(a). Requires the Secretary of Health and Human Services, in consultation with tribes, to identify and utilize, whenever possible, existing federally or tribally owned facilities or local or private facilities suitable for residential treatment centers, pursuant to an agreement between the Secretary and the owner. This agreement may include conditions for the renovation of the facility by the Secretary.

Section 503(b). Requires the Secretary of the Interior to identify potentially suitable BIA facilities for residential treatment centers.

Section 503(c). Requires the Secretary of Health and Human Services, within two years, to advise Congress as to the cost required to construct treatment facilities, if the existing facilities do not meet the needs as identified in the study required by Section 502.

Section 601. Contains the definitions for use in this Act.

Section 602. Authorizes the Secretaries to prescribe necessary regulations.

Section 603. Authorizes the appropriation of such sums as may be necessary to carry out the provisions of this Act. Also requires that any fees charged for instruction under Section 301(b)(4)(B) shall be credited as a refund to the appropriation from which the expenses were paid.

Section 604. Requires the Secretaries to allocate monies appropriated under this Act on the basis of need.

Cost and Budgetary Considerations

The cost estimate for S. 1298, as amended, as provided by the Congressional Budget Office, is set forth below:

U.S. Congress,
Congressional Budget Office,
Washington, DC, November 13, 1985.

Hon. Mark Andrews,
Chairman, Select Committee on Indian Affairs,
U.S. Senate, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office has prepared the attached cost estimate for S. 1298, the Indian Youth Alcohol and Drug Abuse Prevention Act, as ordered reported by the Senate Select Committee on Indian Affairs on November 7, 1985.

If you wish further details on this estimate, we will be pleased to provide them.

With best wishes,
Sincerely,

Rudolph G. Penner.

Congressional Budget Office Cost Estimate

1. Bill number: S. 1298.

2. Bill title: Indian Youth Alcohol and Drug Abuse Prevention Act.

3. Bill status: As ordered reported by the Senate Select Committee on Indian Affairs on November 7, 1985.

4. Bill purpose: To coordinate and provide alcohol and drug abuse prevention services for Indian youths.

5. Estimated cost to the Federal Government:

[By fiscal year, in millions of dollars]

	1986	1987	1988	1989	1990
Estimated authorization level	2.7	1.8	1.9	1.9	2.0
Offsetting collections	−.4	−.2	−.3	−.2	−.2
Total estimated authorization level [1]	2.3	1.6	1.6	1.7	1.8
Estimated outlays	2.0	1.8	1.9	2.0	2.0
Offsetting collections	−.4	−.2	−.3	−.2	−.2
Total estimated outlays	1.6	1.6	1.7	1.8	1.8

[1] Costs of facility renovations authorized in title V of the bill are not included in this estimate.

The costs of this bill would fall within budget functions 500 and 550.

Basis of estimate: This bill authorizes such sums as may be necessary to carry out the provisions of the Act. We assume estimated authorization amounts are fully appropriated at the beginning of each fiscal year. Outlays are estimated using spendout rates computed by CBO on the basis of recent program data.

Title I of this bill would require the coordination of Indian youth alcohol and drug abuse programs that currently exist within the Indian Health Service (IHS) and the Bureau of Indian Affairs (BIA).

Title II would authorize BIA schools and BIA contract schools to provide instruction to students on alcohol and drug abuse prevention. Additional training and materials would be needed to provide this service in all schools. Training costs have been accounted for under Title III of the bill. Instructional materials for all schools could cost about $500,000. The bill would also require the Secretary of Health and Human Services (HHS) to publish and distribute a newsletter on alcohol and drug abuse at an estimated annual cost of $100,000.

Title III would authorize training in alcohol and drug abuse for new Community Health Representatives (CHR). It would also require HHS to make similar training available to BIA and IHS personnel who work with Indian youths. This estimate assumes that all CHR's would be trained. It also assumes that one teacher from each BIA or contract school would be trained as well as all BIA social workers and one staffer from each IHS service unit. We assume training would take place in groups. We estimate the cost of this training to be $1.5 million annually. These costs could vary depending on the actual level of training activity undertaken.

S. 1298 could also provide training for school board representatives, tribal court judges, BIA law enforcement agents and others. The estimate assumes this optional training would be provided at cost. However, an initial appropriation would be required under the bill to cover these costs. The bill states that any fees charged for this training would be credited as a refund to the original appropriation from which training expenses were paid. These fees would be treated as offsetting collections. We estimate that about $600,000 would be needed initially for this training. In 1986, outlays of $400,000 could result and would be fully offset by the collection of fees. The initial funding needed would be lower in future years as only new employees would receive training.

Title IV would require the Secretary of the Interior to prepare guidelines on the establishment of temporary emergency shelters to house Indian youths apprehended on alcohol or drug abuse charges. The bill specifically states that the costs of constructing these shelters is not authorized in S. 1298.

Title V would require the Secretary of HHS to conduct a study determining the population in need and the cost of providing residential youth alcohol and drug abuse treatment. This study would also identify any existing federal or local community facilities that could be used as residential treatment centers. The bill authorizes renovation of such facilities, but no cost for renovation has been included in the estimate. Until this study is completed, neither IHS

nor BIA can estimate the number of facilities that might be needed for residential treatment or the cost and extent of renovation of such facilities.

6. Estimated cost to State and local government: The budgets of state and local governments would not be affected directly by the enactment of this bill.

7. Estimate comparison: None.

8. Previous CBO estimate: None.

9. Estimate prepared by: Carmela Dyer.

10. Estimate approved by: C.G. Nuckols (for James L. Blum, Assistant Director for Budget Analysis).

Regulatory Impact Statement

Paragraph 11(b) of rule XXVI of the Standing Rules of the Senate requires each report accompanying a bill to evaluate the regulatory and paperwork impact that would be incurred in carrying out the bill. The Committee believes that S. 1298, as amended, will have a minimal impact on regulatory or paperwork requirements.

Executive Communications

The only Executive communication received by the Committee was in the form of testimony offered at the September 17, 1985, hearing by Hazel Elbert, Acting Deputy Assistant Secretary for Indian Affairs, Department of the Interior and Robert Kreuzburg, M.D., Acting Director, Indian Health Service, Department of Health and Human Services. The statements follow:

Statement of Hazel Elbert, Acting Deputy Assistant Secretary for Indian Affairs, Department of the Interior, Before the Select Committee on Indian Affairs, United States Senate, on S. 1298, a Bill "To Coordinate and Expand Services for the Prevention, Identification, and Treatment of Alcohol and Drug Abuse Among Indian Youth, and for Other Purposes"—September 18, 1985

Good morning Mr. Chairman and Members of the Committee. I am pleased to be here today to present the views of the Department of the Interior on S. 1298, a bill "To coordinate and expand services for the prevention, identification, and treatment of alcohol and drug abuse among Indian youth, and for other purposes."

We consider alcohol and drug abuse to be the most serious social and health problem facing Indian people today. Our statistics show that the majority of BIA and tribal arrests involve alcohol and drug abuse and that many of those arrested are juveniles.

S. 1298 attempts to address the critical problem of juvenile alcohol and drug abuse in Indian Country by requiring more coordination of information and services between the Bureau of Indian Affairs (BIA) and the Indian Health Service (IHS); training of all personnel working directly

with Indian youth; a more comprehensive education program in BIA schools; alternative placements for children arrested for drug and alcohol related offenses; and more comprehensive alcohol and drug abuse treatment centers which include detoxification facilities, counseling services, and follow-up care.

Although we support some of the concepts addressed in S. 1298, we oppose the bill as drafted. To adequately discuss each of our concerns I would like to briefly comment on each title of the bill.

Title I provides for extensive coordination of information and services between the BIA and the IHS. We agree there is a need for better coordination and we will be happy to pursue it. However, we believe that the Indian Health Service is better equipped to work with the tribes to identify services available to them in their immediate geographic area. Moreover, we question the need for formal tribe-by-tribe agreements to identify and coordinate services which would force assistance to be allocated on first-come, first-serve basis rather than to where the greatest need might exist.

Title II requires that alcohol and drug abuse instructional programs be provided to all students in BIA and contract schools. We believe that this provision would be an appropriate replacement for the Indian school provisions in the Act of May 29, 1886 (24 Stat. 69; 20 U.S.C. 111, 112) which requires similar instruction. We have such programs in place. This school year these programs will be expanded and improved in connection with an interagency agreement with the Department of Justice under which we will receive $150,000 to be used for training school and dormitory staff in alcohol and drug abuse programs and for purchasing classroom materials. Our preliminary plans are to provide training to teachers from 48 schools in eight locations. This program will also provide materials to schools which can be used immediately by the teachers after they receive the training. This program will affect approximately ten thousand students.

In addition, five of our employees will receive training in Seattle and become trainers of a new in-house training cadre. The cadre will be used throughout the Bureau's education system to train other teachers and staff.

Title II also requires the Bureau to publish a quarterly newsletter to report on Indian alcohol and drug abuse projects. This provision is unnecessary. The Bureau recently contracted with TCI Inc. to publish and distribute a newsletter called "Linkages for Indian Child Welfare Programs." We propose expanding this newsletter to include topics on juvenile alcoholism and drug abuse. The first issue published under the contract will be distributed in mid-October and the central article will discuss this very subject. We estimate that within existing resources, we could increase the number of pages of this publication by 25 percent (4 pages) as well as double the number of issues

distributed. This approach would be much less costly than initiating a new publication and could be done immediately without additional appropriations.

Title III requires the IHS to provide training for new community health representatives and aides. We defer to the IHS on this title.

Title IV authorizes the Secretary of the Interior to promulgate guidelines authorizing law enforcement officers to place juveniles arrested for offenses related to the abuse of alcohol and drugs in facilities other than an emergency shelter or a community-based treatment facility. The only other appropriate facilities apparently would be detention facilities. As written, section 401(a) of this Title is unnecessary since the Secretary of the Interior already has authority to place juveniles in detention facilities.

Title IV also requires the Secretary to establish temporary emergency shelters to house Indian juveniles apprehended for offenses relating to alcohol and drug abuse. We recognize the need for some kind of emergency shelter or facility to address the problem. However, we must assure that additional facilities, if any, are not duplicative of the existing networks of special care facilities and foster homes supported by the Indian Child Welfare Act grant program. Therefore, we feel that no new special funding authority is presently needed to establish special new emergency shelters. In using any facilities we would propose using state and tribal licensing requirements as we do under the Indian Child Welfare Act Program. We strongly believe that a properly staffed program can be used as a vehicle for identifying the proper course of action for juveniles with drug and alcohol related problems.

Title V requires the IHS to provide comprehensive alcohol and drug abuse treatment services including detoxification, counseling services and follow-up care in IHS facilities. We defer to the IHS on this title.

Title VI provides a number of definitions which we find acceptable.

In summary, we applaud the Congress in attempting to address this very serious and complex problem and we would be pleased to work with the Committee.

This concludes my prepared statement. I will be happy to answer questions the Committee may have.

DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT ON S. 1298 "INDIAN JUVENILE ALCOHOL AND DRUG ABUSE PREVENTION ACT" BY ROBERT KREUZBURG, M.D., ACTING DIRECTOR, INDIAN HEALTH SERVICE—SEPTEMBER 18, 1985

Mr. Chairman and Members of the Committee: I am Dr. Robert Kreuzburg, Acting Director of the Indian Health Service (IHS). With me is Dr. Craig Vanderwagen, Acting Director, Division of Clinical and Environmental Services, and Mr. Russell (Bud) Mason, Chief, Alcoholism Program

Branch. I am very pleased to be here today to discuss with you and your Committee S. 1298, a bill "to coordinate and expand services for the prevention, identification, and treatment of alcohol and drug abuse among Indian youth".

The Department of Health and Human Services (HHS) and the IHS certainly share the concern of the Committee and Indian communities regarding the serious problem of alcohol and drug abuse among American Indian/Alaska Native youth. The abuse of alcohol and drugs is the most serious health and social problem faced by Indian people. Alcohol abuse is frequently cited as a direct contributing factor in at least four of the top ten causes of death among Indian people, i.e., accidents, liver diseases, homicide, and suicide.

Empirical evidence indicates that this abuse is directly affecting a younger and younger population with grammar school aged children beginning the use of alcohol and abuse of such substances as Lysol, glue, paint and type correction fluid.

While we share the goal of decreasing alcoholism among American Indians/Alaska Natives, we do not support the proposed bill as a means to achieve that goal.

Before turning to a discussion of S. 1298, I would like to present a brief background of alcohol and substance abuse programs among the Indian and Alaska Native people and what the IHS is currently doing in this area.

By 1976, the National Institute on Alcohol Abuse and Alcoholism (NIAAA) was supporting over 160 American Indian and Alaska Natives administered and operated alcoholism treatment programs at an annual level in excess of $16 million. The NIAAA support of community treatment grants was limited by law and Institute policies to an initial three year project demonstration period and one three year renewal. Subsequently, support for the programs was to be the responsibility of State and local funding sources. However, it was the determination of the Congress, HHS, and the Indian people through their respective tribal governments that the Indian alcoholism programs would not survive without continued Federal support. Consequently, the Congress directed the phased transfer of "mature" programs (i.e., programs which had received six years of Institute support) from the NIAAA to the IHS for continued long term support and provided the necessary authority for this transfer in the Indian Health Care Improvement Act, Public Law 94-437. Funding to support Indian alcoholism programs has been a part of the IHS appropriation base since fiscal year 1978.

In fiscal year 1985, 219 alcoholism programs were supported by the IHS at an annual cost of $24.607 million. The 219 programs are funded by contracts between the IHS and a wide assortment of Indian tribes, tribal groups, bands and associations that provide alcohol abuse prevention/treatment services. The IHS encourages alcoholism prevention and promotion activities with programs under

contract with the IHS. The services provided by the contractors vary from program to program. The Indian alcoholism programs offer an array of treatment and prevention services through one or more of the following components: detoxification, primary residential treatment, halfway houses, outpatient care, school-based prevention, community-based prevention, drop-in centers, outreach, and aftercare.

The alcoholism programs conduct prevention activities. Most Indian alcoholism programs provide presentations on alcoholism to youth groups in communities and reservations. The program staffs also work with the Indian leaders to provide promotion campaigns against excessive use of alcohol. They assist school and county government officials in identifying materials and resources that might change community values which reinforce alcoholism and alcoholic behavior.

In addition to programs contracted out to tribes and Indian associations, alcohol abuse prevention/treatment services are rendered through 48 IHS hospitals and over 200 clinics.

School based programs are also operating in several parts of the country. They promote students becoming actively involved in learning effective decision making skills, establishing a positive self-image and activities which help students develop life coping skills. These activities also emphasize campus-wide alcohol and drug abuse intervention programs. Another example is a vocational technical training center, which includes adult students, that is coordinated with a women's halfway house. Prevention activities are integrated into many Federal and State school systems in an effort to decrease the number of teenagers who get involved with alcohol or drugs.

Examples of primary prevention services being provided in outpatient treatment centers include: health education, motivational counseling, self-awareness, values clarification, traditional counseling by elders, decision making, developing coping skills, youth leadership, and life enhancing skills.

Several of these programs use role models very effectively. The use of puppets, charades and plays culturally designed for alcohol and drug education have proven to be very effective. There are a number of programs that have parent-youth groups, teenage pregnancy counseling, crisis intervention, and parenting skills education.

It should be noted that the majority of these programs have primarily targeted alcohol abuse. Congressional intent has been very clear in specifying this programmatic emphasis. Notwithstanding, alcohol abuse is part of the continuum of substance abuse and many current "alcohol program" activities have efficacy in dealing with all forms of substance abuse. Many of the local programs capitalize on this fact to provide broadly based substance abuse services. High risk youth can be characterized in several ways.

They tend to have inadequate knowledge of available community alternative activities, poorly developed or inadequate life coping skills; they demonstrate little or no interest in available organized activities such as scouting, theater, dance groups, band or other after school groups. In response to these deficiencies, special programs provide enrichment activities, work with parents, and developed recreational activities.

The Department supports the intent of S. 1298 which outlines a program aimed at arresting alcohol and drug abuse among Indian youth. Juvenile alcohol and drug abuse has reached epidemic proportions in many Indian communities. The problems are such that the sort of interagency cooperation called for in the proposal is essential if meaningful success is to be achieved. In fact, we are already effecting this cooperation. There are working agreements between the Bureau of Indian Affairs (BIA) agency offices and IHS Service Units and between the IHS Service Units and local tribes in many locations. Also, since 1972 when 50 Office Economic Opportunity funded Indian alcoholism programs were transferred to the NIAAA and an Indian Desk for Support and Liaison was established, a major funding policy was implemented which required all applicants to obtain memorandums of agreement and commitments from all applicable resource agencies in all local Indian communities. The requirement for these agreements has been continued following transfer of the alcoholism programs from the NIAAA to the IHS. They are an integral part of the management of local alcoholism programs and they effect considerable coordination between IHS and other interested parties and organizations. We believe, therefore, that new legislation is not needed to ensure such efforts.

In addition, we believe that S. 1298 contains redundant authority, calls for activities at a national level which can more effectively and economically be done at the local level, would dissipate available resources by directing them into producing national reports and studies and away from services, and has unrealistic schedules for these reports.

The agreement between the Secretaries of the Interior and Health and Human Services called for in section 101 demonstrates the above points. The agreement covers a very wide scope and is to be developed in consultation with the Indian community, submitted to the Congress and published in the Federal Register all within the short span of 180 days from enactment. The agreement is to include permission for local IHS and BIA officials to enter into agreements with tribes to coordinate alcohol and drug abuse services and resources. This authority already exists for tribes under the Indian Self-Determination Act, use of which would have the additional benefit of providing the tribe with those funds that IHS has been spending on the effort. Coordination and identification of available re-

sources are two efforts we believe are most beneficially and economically performed at the local level.

However, we have no objection to entering into a general agreement with the Secretary of the Interior. We agree with the thrust of section 101(a)(3) that BIA and the IHS should better define which agency is responsible for what services in order that the client not be bounced from agency to agency, but we do not believe legislation is required. We believe this can best be accomplished at the local level taking into account both the nature and severity of the problem and the total resource available from all sources.

We defer to the BIA on Title II—Education.

Title III—Family and Social Services, mandates certain training activities including a minimum of two weeks training for new Community Health Representatives (CHR) and health aids on the problems of alcohol and drug abuse. The President's budget for fiscal year 1986 does not provide for continued funding of the CHR programs. In addition, section 301(b) requires the Secretary to provide certain training, upon request, to a long list of eligibles but does not make this dependent upon the appropriation of additional funds. The Secretary could, therefore, be put in the position of appearing to refuse to provide mandated training or of having to use funds that were meant for other purposes.

We defer to the BIA on Title IV—Law Enforcement. However, we are not clear what is meant by the "concurrence" of the Secretary of Health and Human Services in the establishment of temporary emergency shelters nor what "temporary" means.

There are a number of problems and inconsistencies in Title V—Juvenile Alcohol and Drug Abuse Treatment and Rehabilitation. The requirement in section 501(a) that the President must include a funding request in subsequent budget submissions is inappropriate in that it impinges upon the President's authority and responsibilities to determine what funding he believes should be recommended to the Congress. Section 501(c) further complicates the situation by requiring the Secretary to report on programs established under section 501(a) without any assurance that the Congress will have appropriated implementing funds, even if the President were to recommend funding. Programmatically, section 501 sets up a program that relies only on IHS and P.L. 93-638 contractor facilities. This is at variance with other provisions of S. 1298, e.g., section 502, and the current practice of identifying and relying on all available resources.

Section 503 is based on the premise of the Secretary of Health and Human Services having the sole responsibility for residential alcohol and drug abuse treatment centers for Indian juveniles. We believe this could go beyond the health related authority and responsibilities that were transferred to the Public Health Service in 1954 and could

remove or cloud the responsibility of the Secretary of the Interior for the social service aspects of the overall program.

We are in harmony with the Congress' effort to affect the alcohol and drug abuse problem in the Indian community but we oppose enactment of S. 1298.

That concludes my statement. I will be happy to answer any questions you may have.

CHANGES IN EXISTING LAW

In compliance with subsection 12 of rule XXVI of the Standing Rules of the Senate, the Committee notes the following changes in existing law (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

Subsection (a) of section 423 of the Indian Education Act (20 U.S.C. 3385b(a)) is amended as follows:

SEC. 3385b. FELLOWSHIPS FOR INDIAN STUDENTS—

(a) Number for each fiscal year; graduate and professional program studies; academic year limitations; award of vacated fellowships for remainder of period.

During the fiscal year ending June 30, 1975, and each of the succeeding fiscal years ending prior to October 1, 1989, the Secretary is authorized to award fellowships to be used for study in graduate and professional programs at institutions of higher education. Such fellowships shall be awarded to Indian students in order to enable them to pursue a course of study of not more than four academic years leading toward a postbaccalaureate degree in medicine, *clinical psychology,* psychology, law, education and related fields or leading to an undergraduate or graduate degree in engineering, business administration, natural resources, and related fields. The Commissioner may, if a fellowship is vacated prior to the end of the period for which it was awarded, award an additional fellowship for the remainder of such period.

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